VERMONT

Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495-2086

Agency of Human Services

Treatment to Control Harmful Habits Prior Authorization Request Form

(Effective 08/01/07)

(Please Print or Type)

1. Patient Information:

Patient Name: _____

Date of Birth: _____ Age: _____

Address: _____

Parent(s) Name: _____

Patient Medicaid I.D. Number: _____

Referring Dentist: _____

Preventive and restorative treatment completed to date: ☐ Yes ☐ No

Oral Hygiene: ☐ Good ☐ Fair ☐ Poor

2. Diagnosis:

Dentition: ☐ Primary ☐ Transitional ☐ Adolescent ☐ Adult

Angle Class: ☐ I ☐ II ☐ III

Overbite: _____mm Overjet: _____mm Crowding: _____mm

3. Proposed Treatment:

Treatment to Control Harmful Habits (check one code): ☐ D8210 ☐ D8220

☐ Upper Arch: ☐ Fixed ☐ Removable Appliance: _____

☐ Lower Arch: ☐ Fixed ☐ Removable Appliance: _____

*Eligibility for Treatment to Control Harmful Habits requires documentation of the harmful habit.

(Continue on back)

4. <u>Additional Information</u>:

Estimated time: _____

Requested Fee: _____

Date Submitted: _____

Submitted by:_____

Medicaid Individual and Group Provider Number(s):_____

I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her condition as set forth herein is accurate to the best of my professional judgement.

Provider Signature:_____

Submit this PA request and all supporting documentation to:

Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, VT 05495
Fax: (802) 879-5963